Special Presentation to the State Legislature: Hawaii Coalition for Health December 8, 1999

When it comes to health care, the future is best seen not by adopting a global perspective, but rather by focusing on what is purely local. An island community like Hawaii cannot depend on a phone or fax line, or the next airplane or ship, to bring dedicated, experienced, and qualified health care professionals to its shore. Hawaii must preserve within its own community the sensitive hands and intuitive minds of experienced specialists; the nurses and doctors attuned to the needs of a multiethnic and multicultural community; and the rural and primary hospitals that are accessible to all.

The Hawaii Coalition for Health is a consumer health advocacy organization that seeks to remind decisionmakers and the public that providing optimum care for patients depends on preserving the health of all components of our health care industry, from institutional providers to individual providers, from health plans to the professional schools. Since its inception in 1996, the Coalition has provided balance to a health care industry where health plan management felt free to diminish the quality and quantity of patients' medical care at will.

The health of Hawaii's health care industry impacts not only consumers and current practitioners, it impacts the future of the University of Hawaii professional health schools and their graduates as well. The Schools of Medicine, Nursing, and Public Health contribute enormously not only to the quantity of health care in our community, but also to the high quality of health care in this State. The symbiotic relationship between our professional health schools and providers throughout the State needs to be considered and nurtured by policymakers.

Informed policymakers can formulate and implement policies that will preserve and support all facets of Hawaii's health care industry. In 1998 and 1999, our Legislature enacted statutory protections for patients that helped to level the playing field for both patients and providers. However, the Coalition is now concerned that the imbalance of bargaining power between managed care organizations and providers will undermine those protections. On December 8, 1999, the Coalition convened a panel of experts to share their concerns about the current state and future prospects of health care in Hawaii. The following articles represent those experts' viewpoint in their primary areas of concern.

Arleen Jouxson-Meyers Esq., MD, JD, MPH, President, Hawaii Coalition For Health

The Hawaii Coalition For Health, for those who don't know about the organization, is a 3-year old 501(c)(3), non-profit corporation established to advocate for consumers in any matters which affect health. The organization, presently with a membership of about 1,200, comprising 400 physicians and other professionals, and 800 general public, provides a forum for consumers to become involved and to participate in policy making regarding how their health care is delivered. The Coalition believes that it is time for all of us to take our heads out of the sand and to bring the problems that exist into the sunshine, and to end the downward trend in the quality and availability of health care delivered in Hawai'i, before we totally lose the fruits of many years of hard work.

The Coalition hosted a meeting at the legislature on December 8, 1999 with a purpose of raising awareness of the serious problems that exist and hopefully to spur our legislators to create a forum in which we can, as a community, explore solutions. I would like to thank Senator Suzanne Chun-Oakland and her staff for assisting us in setting up the meeting. Unfortunately, due to some mis-communication that occurred, many of our key legislators were unable to attend, but I hope that by their staff carrying back information to them, we can still accomplish our objectives. I would also like to thank Professor Sylvia Law, a visiting law professor from New York University, for permitting me to use data which have resulted from research she is conducting.

In some respects Hawai'i stands out as a leader in our nation: Firstly, because only 8.8% of our population is uninsured, whereas, 16.3% of Americans nationwide were uninsured in 1999, substantially more than when managed care took hold in the late 1980's and we were promised that more Americans could be insured out of savings generated by more efficiently managing health care costs. Secondly, Hawai'i's health care costs are lower than the rest of the nation. We spend roughly 11% of Gross State Product on health care versus 15% nationally. In light of the fact that Hawai'i's life expectancy is 79, four years longer than the U.S. average, our low expenditures on health care is even more remarkable. In other respects, perhaps, Hawai'i has cut too close to the bone and, similar to the federal government recently re-evaluating Medicare reimbursements, we should reconsider whether we too have gone too far.

Numerous problems are emerging in Hawai'i: Firstly, our hospitals are facing serious financial difficulties. We recently heard that Wahiawa General Hospital had defaulted on its State bonds. Kahuku Hospital has been considering closure for quite a while. The hospital CEO's and Rich Meiers from the Healthcare Association of Hawai'i were not present at the legislative meeting because they were meeting with Governor Cayetano at the time and were holding a press conference to inform law makers and Hawai'i's people of the critical problems faced by our hospitals. I have personal knowledge from my participation on the medical staff of certain hospitals, and as a patient, that the safety and quality of care has been dangerously

eroded over recent years. I chose not to single out any one hospital in a public meeting, because as victims of virulent health insurance reimbursement practices, they are all engaging in similar cost-cutting measures which have led to less availability of unprofitable services, demoralization of our nursing profession, and unsafe and poor quality care being delivered. Some have tried to diversify their revenue sources by starting health insurance plans, but have not had the economic power to compete in the insurance market place and have been consumed by our more powerful health insurer. Secondly, the medical school and other health professional schools are no longer adequately supported by the State or by the hospitals. We well know that the presence of health professional schools in a community not only facilitates provision of culturally sensitive care, but plays a direct role in the safety and quality of care delivered. By being able to rub shoulders, on a day-by-day basis, with academicians, practicing professionals are able to maintain a very high standard of knowledge and current expertise which in turn relates to a greater degree of safety and quality for our patients. For goodness sake, we live on an island unable to drive to the next tertiary care center in a neighboring state. If we cannot meet our own needs, we are dead in the water. Sadly, we have already lost our School of Public Health, and we have no assurance that we can get a program of public health accredited. Thirdly, Hawai'i's physician population has been deprofessionalized and is struggling to survive. A notable number of my physician colleagues have difficulty paying the rent, and some, especially the more senior and more experienced are leaving Hawai'i, leaving more of our health care to newly graduated and inexperienced physicians. They too cut costs by reducing the number of qualified nurses they employ and by providing a lower quality of care than before. Furthermore, the way physicians practice medicine and what they can do for their patients is controlled by health insurers through enforcement of one-sided and unfair contracts. Doctors in Hawai'i, because of the monopolistic power of one health insurer, the Hawai'i Medical Service Association, to whom physicians must sell their services or go out of business, are therefore powerless to advocate for their patients' rights. Fourthly, Hawai'i has a far greater percentage of uninsured children than in the United States as a whole. In 1997, 9.8% of all children in Hawai'i had no health insurance, and 13.1% of children were under six years of age. Even in light of these statistics, Hawai'i has not claimed the $8.9 million federal dollars available to cover children under the CHIP program. Lastly, Hawai'i's community health centers play an essential role in providing care to uninsured and in keeping the cost of health care low, yet we are threatening the viability of these centers by permitting unreasonably low capitation payments which prevent them from adequately caring for the uninsured and for patients with multiple medical needs.

It can be easily seen that these complex problems cry out for a collaborative approach to problem solving, not the heavy-handed and one-sided mechanisms that are often presently used. Each and every one of us can count on one fact: we will need health care at some time in our lives. Let us guard against further erosion of our access to high quality and safe health care.

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It is a pleasure for me to be here today and share with you my vision for our medical school. I am delighted to be the Dean of the John A. Bums School of Medicine. There is nothing I would rather do than be the Dean of this medical school. I share your concerns, aspirations and dreams for the school. I chose to come to Hawaii because I believe that the Governor, the Legislature, the University, the community, the hospitals, the faculty, the physicians of Hawaii and the students want to be a part of an excellent medical school.

To achieve our goals of excellence will require all of us to rethink what it is we wish our medical school to become. Some of the faculty will need to redirect their energies and talents in different directions to accomplish these objectives.

A Medical School's success is measured many ways. For a community the yardstick of success is often related to the positive influence it has on the well-being of the health of the citizens in the region and state, and the impact it has on the advancement of medical science. For a single individual, it may be how effective someone was at the school in helping you or a friend resolve a personal illness or identify an appropriate referral to a competent physician. For you, the state legislature, it may be the return on investment that you have made in the medical school.

People have always had a great interest in medicine and health. Most communities in which a medical school is located, take great pride in their medical school, and enjoy, in fact, take great pride in the success of the students and faculty.

There are many clinical settings in which medical schools are expected to be leaders. These include the study and evaluation of human health and disease, not only in the health of populations, the purpose of which is to improve the health of groups of people; but, also in the basic science investigation of the molecular biology of disease. Most medical schools provide the clinical leadership in selected areas where innovation and clinical research are required to advance and improve our diagnostic capabilities and treatment options.

My vision is that our medical school should become more involved in the research that is critical to the future understanding of disease. And from this research become recognized leaders in the new biomedical revolution.

My vision includes programs devoted to how to measure and document the difference between good patient care and outstanding patient care. And then communicate these findings effectively to patients and physicians. As a profession, we can do a lot better in the defining the quality aspects of patient care. We must be the paragons of excellence in medical care, and learn how to communicate more effectively to our patients and their families. We must teach them what excellent medical care is, so that they can become more involved in the decision process regarding their diagnosis and treatment.

Medical schools traditionally have had the responsibility for the leadership in continuing medical education of the faculty and local physicians and other health care professionals within the region.

Some schools have also assumed the leadership in the use of information technology to assist physicians and patients achieve access to medical knowledge and care options.

My vision is that we enhance our efforts in continuing medical education, so that we can become a site of choice for continuing medical education for mainland physicians. A mature continuing medical education program could attract thousands of physicians and their families to Hawaii annually. These programs would be a few days to a week in length, with multiple different topics covered over the year. And, of course, medical schools have the sustaining reputation of being the crucible of new knowledge that affects and advances our understanding of health and disease from which improved patient care comes.

The foundation on which all medical schools are built is their commitment to education. The original purpose of a school was to educate, and in so doing, make certain the future generations of physicians are better than we are. Therefore, a significant measure of success can be determined by the quality of our students and their future successes in whatever it is they chose to do. Our students are indistinguishable in their academic accomplishments from those students of the best medical schools in the country, including Harvard and Yale. We standout as a leader in our commitment to accepting the student of a different cultural background. We have the most diverse student body of any medical school. And, we have proven to others that diversity is an asset.

We graduated our first four-year class in 1975, since then our medical school has graduated 1554 students. Sixty percent of Hawaii's physicians are graduates of the John A. Burns School of Medicine or trained in our residency programs. There are 1100 applicants for a class of 62, *25%* of whom are graduates of the University of Hawaii. Six to ten are out of state residents. Ten years ago, our medical school began what is called Problem Based Learning, or PBL. This was a radical departure at the time from the traditional training process, which was two years of lectures followed by two years of practical experience in a hospital. PBL is focused on specific patient diagnosis or set of clinical problems. The learning is done in small groups of 5 to 6 students, referred to as tutorials, supervised by faculty. The focus of these tutorials is to stimulate the student into thinking about information and analyzing data. There are lectures, but they are related to the clinical problem under discussion. Our medical school has received national recognition for this program, and many students apply here because of it.

My vision is to build on the successes of this innovative educational program, and use the new electronic technology to enhance the educational process. In so doing we can consider exporting segments of our programs to other schools and medical students. We have plans to work more closely with the neighboring islands of Hawaii in our educational programs.

In addition to doing so well in student education, to achieve a national reputation of excellence, a medical school must demonstrate excellence in research-both clinical research and basic research. Fortunately, there are funds available from federal and private sources for which we can compete to support our research endeavors. Great medical schools are not dependent on state funds for all of their support, but generate substantial dollars from these national funding sources.

The National Institutes of Health, best known as the NIH, is a federal agency whose only purpose is to support biomedical research, mainly through a competitive grant process. It has a budget of 15.7 billion dollars; and both the republicans and democrats are committed to doubling this funding over 5 years. In this year's 2000 budget there is an additional 2.3 billion dollars earmarked for the NIH, which will bring the total NIH spending authority to 18 billion dollars. Private foundations, such as the American Cancer Society, American Heart Association, American Diabetes Association, the Howard Hughes Medical Institute and pharmaceutical companies contribute in excess of 50 billion dollars toward the nation's biomedical research efforts.

Another vision I have is to recruit physician-scientists as well as basic science investigators who can compete successfully for these dollars. Faculty will be recruited whose research will influence the future of our thinking about the normal and abnormal condition, improve the diagnoses or treatment of human disease, or help us understand why there are different rates of illness in people of different ethnic origins.

Biomedical and clinical research is an industry that can become an economic engine. Successful investigators bring new dollars into a region and state through their grants and contracts. In many instances, these can average 1 to 2 million dollars per year for each research team. An average faculty member has 2 to 3 grants that total half a million to a million dollars. These research teams hire support staff, including research technicians, administrative personnel, and provide the training ground for young scientists and physicians who will be the future faculty and practitioners. In addition to these immediate benefits, discoveries made in these laboratories are often the genesis of new small biotech companies that develop in the surrounding communities.

Many of our faculty are considered leaders in their chosen fields of investigation, but we need more of them. I hope to provide the infrastructure that will help the current faculty become even better at what they do.

With a long-range strategic plan that establishes the areas in which we wish to excel, we can recruit additional faculty to join those who are here. We will create an office of research at the Medical School that will assist the medical school faculty in writing grants and the required reports. This office will also work closely with those who do clinical research to make certain that patient data is collected in a timely and accurate fashion; and that all of the federal and state mandates related to clinical research are followed.

The reputation of a medical school cannot be made on education alone, there needs to be the appropriate mix of education, which must be done in an exemplary fashion, AND innovative, well respected and recognized research.

A successful medical school will be an asset to the city of Honolulu and the state of Hawaii. It will be an economic engine that brings in new dollars, it will become nationally recognized for excellence in education and research, it will be a school that outstanding faculty will want to join. We can develop a reputation that parallels those of the Mayo Clinic, Yale, Harvard, Johns Hopkins, Stanford, and the Cleveland Clinic. We must think big and believe. We have an asset that no one else has-we have Hawaii! A destination on everyone's list; the most culturally diverse population of any state; and, a geographical location that provides us the great responsibility to help others in the Pacific region.

We can recruit to Hawaii. What is needed is the infrastructure for our new faculty to work. We need to view the medical school and our faculty, as any other business-our product is education, research and clinical care. To be productive, as with any other business, requires appropriate space equipped to meet the needs of the 21st century.

I do believe that the state should be the sole or even the major source of funds for the medical school. I expect the state to be a partner with the federal government and private foundations. The state currently contributes 15 million dollars to our 60 million-dollar budget. These figures do not include the time that the private physicians donate to the education of our students and young physicians in training, the 250 residents. Already your support is being leveraged at a rate of 4 to 1.

I wish to comment briefly on the School of Public Health. First I welcome this school into the medical school. I consider public health an important discipline. A measure of personal success for me in five years will be the success of the school of public health. I will do what is necessary to build the school, not dismantle it further. For you to be blamed for the deterioration of the school of public health is inappropriate. The real issue was that the school did not have balanced portfolio of funded research to sustain the academic mission.

I wish to lead both the Medical School and the School of Public Health into a situation where funding is from a variety of sources, so that we will be less vulnerable when any one funding agency sets different priorities.

I view the State as our KEY partner, AND you have demonstrated your wisdom and leadership over the years by constructing buildings and providing the operating dollars to sustain the administration and essential faculty of the school. The Institute for Biogenesis Research is just the most recent example.

I am meeting with community leaders, you, the state legislature, the University administration, the faculty, the students, our State senators, Inouye and Akaka and congressman Abercrombie and congresswoman Mink. From their input we will develop a strategic plan. I will share this plan with you. A partner needs to be involved in the thinking and creation of the plan. I promise that I will never surprise you with a request. I will never blame you for our shortcomings. All I ask is that you become an involved partner.

Before I close, I want you to know just how outstanding the hospitals are in Honolulu. These hospitals compare favorably with the best in the country. These hospitals offer a strength that most medical schools do not have. As you know, medical students' major patient-directed education occurs within the hospital or clinic setting. The private physicians and clinical faculty are equally impressive, and also compare with the very best in the country.

If we set our standards high and look beyond the nearest horizon, we can become a medical school with a national reputation for excellence in all areas. I want the John A. Burns School of Medicine to be a school of which our faculty, our community, and our State can be most proud. An excellent medical school sets the standards of health care expectations. I want our school to set the highest standards; I want to prove to our community the value of having a medical school. I never want there ever to be even the whisper of closure. It is my responsibility as dean to communicate effectively with you and others in the community so that over time we can all understand the extraordinary value that a medical school can have in a community.

Sylvia A. Law JD, Elizabeth K. Dollard Professor of Law, Medicine, and Psychiatry New York University School of Law

I am honored to be included in this illustrious group. I am Sylvia A. Law, the Elizabeth Dollard Professor of Law, Medicine and Psychiatry at New York University Law School. Since 1970, I have studied health care financing, written many books and articles, and done legal work to improve access, costs and quality for all people. I came to Hawaii to learn from you.

You have many reasons to be proud of your health care system. You do better than any state in assuring the benefits of health insurance coverage. Your network of community health centers is the best in the Nation. Your commitment to public health, exemplified by your clean needle law, is unparalleled.

There is so much to admire in Hawaii health care that it seems ungracious to talk about problems. Nonetheless, that is what I will do. In the short time available to me, I want to address two problems: first, the need for more probing Insurance Department scrutiny of HMSA, and second, child health care.

Dr. Meyers and Professor Miller have made a strong argument that HMSA does not treat physicians in a way that it is fair and reasonable, and that patients suffer as a consequence. I do not know enough to evaluate the substantive merits of these claims. But I do believe that they deserve to be taken seriously.

HMSA exercises a market power in Hawaii that is greater than any single insurer has in any other state. HMSA wields monopoly power as a seller of health insurance and monopoly power as a purchaser of the services of health care providers. It has enormous capacity to exercise control. Functionally, Hawaii has a "single payer" health insurance system. Progressive people often favor a single payer form of health insurance, recognizing that a powerful payer can do sensible planning and negotiate with providers on behalf of patients. But here the single payer is not the government, but a private organization, HMSA. My early impression is that HMSA does a pretty good job in many ways. Because HMSA exercises such great power, it should be held to high standards of fairness in both process and substance. The Insurance Commissioner is the most likely candidate for the job.

In short, Hawaii is unique in that HMSA has so much power. Because it has so much power, the people—consumers, patients, employers, tax payers, hospital, doctors, and other providers—have a special interest in knowing that it is acting fairly and reasonably.

Hawaii seems to be unique in another respect. In most states, all insurers are required to file rates with the Insurance Commissioner, and he or she is required to approve them as "fair, reasonable and non discriminatory." Frankly, in most times and places, insurance commissioners rubber stamp the rates submitted. But they have the general statutory power to probe and to disapprove rates that are not fair and reasonable. Insurance commissioners in other states have used such general regulatory authority to oversee contracts between health insurance companies and health care providers.[1] In Hawaii, the Insurance Commissioner plainly has this power in relation to casualty, surety, property, marine and transportation insurance.[2] I understand that the Commissioner has used this power to review auto insurance and return money to insured people. Beginning in

2000, health insurers are required to pay the Insurance Commission $10,000 per 70,000 non-governmental members, "to defray any administrative costs, including personnel costs, associated with health insurance regulation."[3] The mandatory fund plainly implies significant insurance department regulation of health insurance. In addition, the Insurance Commissioner has broad subpoena power.[4] The Hawaii Insurance Code is not a model of clarity.

HMSA should be subject to scrutiny and regulation by the Insurance Commissioner. The Commissioner should assure all the people that rates paid are fair, reasonable and non discriminatory. He or she may have that authority under current law. If this is not clear, the legislature should affirm that the Insurance Commissioner should assure that rates to both consumers and providers are fair, reasonable and nondiscriminatory.

I would like to briefly address another issue: child health. While Hawaii generally does a better job than most other states in providing health insurance coverage and care, children in the Islands are less likely to have insurance coverage, either public or private, than the population as a whole.[5] In 1999, estimates of the number of Medicaid and QUEST eligible children who were not enrolled ranged from 4,500 to 13,000.[6] Several factors contribute to high rates of uninsured children. The Prepaid Health Care Act mandates coverage for full time employers, but not for dependents.[7] The QUEST application process is extraordinarily complex and slow.

The lack of health insurance for children has many adverse consequences. Despite the state's generally good health statistics, the rates of measles, mumps and rubella — classic childhood diseases that can be prevented by immunization — are higher in Hawaii than in the rest of the United States.[8]

In 1997, Congress created the Children's Health Insurance Program (CHIP) to provide federal funds to states to "enable them to initiate and expand the provision of child health assistance to uninsured, low-income children."[9] Under the CHIP program, Hawaii is entitled to $8.9 million in federal dollars a year from 1998 to 2003.[10]

When CHIP went into effect in 1998, many states were ready with programs to claim the maximum amount of federal funds available to provide health insurance to low income children not eligible for Medicaid.[11] Most states are now in the second or third phase of their CHIP programs.[12] In fiscal year 1998, Hawaii failed to claim $9 million in federal dollars available to it to provide heath services to low income children. The state passed up the additional $9 million federal dollars available to it in 1999. On Oct.22, 1998, Hawaii filed an application to participate in CHIP in 2000. The state requested $602,566 to serve 440 children in the year 2000, and an additional $581,045 to serve an additional 440 children in the year 2001. Hawaii's proposal was quickly approved by the federal Health Care Financing Administration. But the state legislature has appropriated no funds to implement CHIP. Rather, the state Senate passed a resolution promising to devote 35% of a possible settlement in national tobacco litigation to "the department of health for health related programs, including the children's health insurance program." Hawaii may be the only state in the U.S. that has failed to claim federal CHIP money.

Why would Hawaii, the Health State, leave eighteen million dollars to care for low income children in Washington in 1998 and 1999, and then claim only a half million of those dollars for the year 2000? The answer is not that the children of Hawaii are already well served. The 1990s were economically difficult for Hawaii, but tourism has now again reached record levels. Other poorer states have picked up their CHIP money. Hawaii spends a smaller proportion of its budget on Medicaid than most states. In many contexts, Hawaii understands that you need to spend money to make money. In the case of CHIP, the federal government guarantees *65* cents for every 35 cents that the state invests. This is a secure investment. Further, Hawaii accurately can tell prospective investors that health care costs are low and workers are healthy. Finally, health care is Hawaii's second biggest industry, behind tourism, and growing the health care sector also grows the economy.

Some suggest that any effort to enroll children in CHIP is likely to find additional children who are eligible for Medicaid. There is a widespread belief among health policy makers in Hawaii that the state is prohibited from spending any more on health care services for low income people than it was spending when QUEST was adopted. This fixed pie constraint is often attributed to the federal government. But, the federal budget neutrality requirements allow adjustments both for inflation and for an increase in the numbers of people qualified for AFDCITANF, and children eligible for GA and SHIP. Further, administrative costs for QUEST are not subject to the federal budget limit and the federal government pays a 90% match for the development of the QUEST information system. Alternatively, the fixed pie assumption is attributed to poor economic conditions. But as the economy improves, it becomes more obvious that the decision to cap state spending for health care for poor children is a political choice, not compelled by any external or legal force.

In sum, I have two suggestions. The Insurance Commissioner should scrutinize relations between HMSA and providers and insist that rates and payment procedures be fair and reasonable. Hawaii should pick up its federal CHIP money for health services for low income kids.

References

1. *See e.g.* In re Rae Filing of Blue Cross Hosp. Serv., Inc., 214 S.E.2d 339 (W.Va.1975)(commissioner's statutory duty to determine that subscriber premiums were reasonable created an implied authority to determine that payment rates to hospitals were reasonable).
2. Haw. Stat. Ann. § 431:14-101 (1999).
3. Haw. Stat. Ann. § 431:2-216 (1999).
4. Haw. Stat. Ann. § 431:2-204 (1999).
5. In 1997, 9.8% of all children in Hawaii lacked health insurance, and 13.1% of children under age six had no insurance coverage; "the percentage of the uninsured who are children is higher in Hawaii than in the U.S. overall." HEALTH TRENDS IN HAWAII, 1999, 104-105.
6. The low estimate is provided by the state Health Department, based on a telephone survey. The higher estimate is provided by the State Primary Health Care Association. Helen Altonn, *Groups Seek Kids With No Insurance: A Campaign Tries to Enroll Children Eligible for Health Care Assistance,* HONOLULU STAR BULLETIN, A-1, July 15, 1999.
7. Haw. Rev. Stat. § 393-13 (1974).
8. HEALTH TRENDS IN HAWAII, 1999, *supra* n. — at 26.
9. The Balanced Budget act of 1997, Pub. L. 105-33, Title IV, 111 Stat. 251 105th Cong, 1st Sess., 1997. (Hereinafter BBA). BBA § 2101 (a).
10. Hawaii Title XXI Program, Submitted Oct. 22, 1998, approved, Jan 19, 1999, effective Jan. 3, 2000. [Hereinafter Hawaii CHIP Plan.]
11. National Governors Association, *Nation's Governors are Proud Partners in Effort to Expand Health Insurance to America's Children: States Act Quickly to Seek Out and Enroll Uninsured Children,* Press Release, Feb. 18, 1998.
12. American Academy of Pediatricians, STATE ACTIVITY IN RESPONSE TO TITLE XXI (SCHIP), available www.aap.org/advocacy/newplans.htm, updated Nov. 1999. [Hereinafter, AAP, 1999].